IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7005 1160 0000 1506 9032

December 3, 2008

Gerald Bosen, Administrator
Weiser Rehabilitation & Care Center
331 East Park Street
Weiser, ID 83672

Provider #: 135010

Dear Mr. Bosen:

On **November 20, 2008**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Weiser Rehabilitation & Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 16, 2008**. Failure to

submit an acceptable PoC by **December 16, 2008**, may result in the imposition of civil monetary penalties by **January 5, 2009**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations.*

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **December 25, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 25, 2008**. A change in the seriousness of the deficiencies on **December 25, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 25, 2008** includes the following:

Denial of payment for new admissions effective **February 20, 2009**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 20, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a

separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 20, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **December 16, 2008**. If your request for informal dispute resolution is received after **December 16, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

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December 18, 2008

Gerald Bosen, Administrator
Weiser Rehabilitation & Care Center
331 East Park Street
Weiser, ID 83672

Provider #: 135010

Dear Mr. Bosen:

On **November 20, 2008**, a Recertification, Complaint Investigation and State Licensure was conducted at Weiser Rehabilitation & Care Center. Karen Marshall, R.D., Lynda Evenson, R.N., Amanda Bain, R.N. and Lea Stoltz, Q.M.R.P. conducted the complaint investigation. The complaint investigation was done is conjunction with the annual recertification survey.

The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003821

ALLEGATION #1:

The complainant stated the identified resident had open wounds on the legs. The physician's order on September 29, 2008, was for daily wound treatments at noon. The resident wanted the treatments done more frequently. On September 30, 2008, at about 5:00 p.m., the family talked to the resident's physician and requested the wound treatments occur more often. The physician stated the order would be changed to twice daily. As of the date of the complaint, the facility is still only doing the treatments once a day at noon.

FINDINGS:

The identified resident was first admitted to the facility on September 29, 2008. She was readmitted on November 19, 2008.

November 2008 Physician's Orders included an order for wound care every morning, dated September 29, 2008. The order included steps for irrigation, debridement and application of medicated solution prior to the application of gauze wrapping to the legs. Review of the Medication Administration Records (MAR) indicated the treatment, as ordered, had been completed daily since admission. Physical Therapy was responsible for the treatment Monday through Friday, and facility's nurses documented doing the treatment on Saturdays and Sundays. On October 30, 2008, a Condition Change Form in the Resident Progress Notes stated the resident was complaining of the dressings being wet. The entry also stated nursing had been changing the outer wrap when the resident had complained in the past. This was verified during review of the Treatment Record for October 2008, which showed the outer wrapping had been changed on ten occasions between October 9, and 31, 2008.

A Physician Telephone Order, dated October 31, 2008, stated the dressing change was to be done daily as described, and added the order to change the outer wrap dressing material in the afternoon and evening. The Treatment Record documented the outer wrap dressing change was documented as having been completed evenings and nights daily from November 1 through November 13, 2008.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant reported a family friend had taken advantage of the resident financially. The incident involved the friend having the resident sign a "falsified" student loan application. The complainant reportedly requested the facility prevent the friend from visiting the resident and the facility placed a sign on the resident's door asking visitors to report to the nurses' station before entering the room. The complainant stated the facility did not inform all staff of the visitor restriction and that the friend got in to see the resident on October 29, 2008.

FINDINGS:

A surveyor interviewed the identified resident on November 19, 2008, at 10:45 a.m. When asked about the sign on her door, which directed all visitors to the front nurses' station before entering, she stated she knew why it was there. She stated that during a previous hospital stay, a family friend had asked her to sign a paper for a loan. She misunderstood the terms of the arrangement and had help getting out of the situation. When asked if the friend had made any further contact with her at the facility, she stated he had not been back to the facility to see her, and if he had, she did not know about it. She stated, "No one has come except my own family."

Resident Progress Notes documented a call from the identified resident's Power of Attorney (POA) on October 29, 2008. The entry stated a complaint had been filed with Adult Protection by the POA and the resident "allegedly is not to have contact with the resident."

The facility's Social Worker was interviewed on November 19, 2008, at 1:35 p.m. When asked about her knowledge of the visitor restriction, she stated that despite a long knowledge of and friendship with the identified resident, she had not shared the details of the incident with her. She further stated it was her understanding that the resident's family placed a sign that restricted visitation on the door on October 30, 2008. Social Services documentation in the resident record also stated the sign was on the door on October 30, 2008.

Documentation was present on October 29, 2008, that the friend/visitor in question was present in the facility on that date, however, no evidence was present that the facility was informed prior to that date, that there was a desire to restrict the visitor.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135010	A. BUILDING _____ B. WING _____	11/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEISER REHAB & CARE CTR	331 EAST PARK STREET WEISER, ID 83672

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations were cited during the annual Recertification survey and Complaint Investigation of your facility. Surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Lea Stoltz, QMRP Lynda Evenson, BS, RN Amanda Bain, RN Survey Definitions: MDS = Minimum Data Set RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record PRN = As needed FDA = Food and Drug Administration CNS = Central Nervous System RCM = Resident Care Manager	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED DEC 16 2008 FACILITY STAFF	
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility did not ensure a homelike environment was provided	F 252	**F 252** **Corrective Measures** Residents # 3, #15, #16, #18,#19, and # 22 have been assessed for the desire and/or need to receive medications during meal times. The Care Plans have been updated for the Individuals assessed to be appropriate for medication administration in the Dining Room. Residents' #17, # 21 & 23 have been discharged from the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gerald Bose — TITLE: Executive Director — (X6) DATE: 12/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252	Continued From page 1 when medications were given in the Sycamore and Willow dining rooms for 1 of 11 sampled residents (#3) and 8 random residents (#s 15 - 19 and #s 21 - 23) observed receiving medication during meals. Additionally, the Sycamore dining room breakfast food items were not removed from the trays. Findings include: 1. Resident #15 was admitted to the facility on 1/2/07 with diagnoses of multiple sclerosis, urinary incontinence, and depression. On 11/18/08 at 8:25 a.m., an LN was observed to pass medications to the resident during her breakfast meal. Resident #15's current Comprehensive Care Plan Report (Care Plan), dated 10/16/08, did not document that the resident was to receive medications during dining. On 11/18/08 at 8:35 a.m., the LN was asked if she routinely gave Resident #15's medications to her during her meals. She stated she gave the resident her medications at meals because she was afraid that if she didn't the resident may choke. She stated the resident wanted to lie down immediately after meals. Resident #15's current Care Plan, dated 10/16/08, documented that the resident was to, "Remain upright for thirty minutes after oral intake." 2. Resident #16 was admitted to the facility on 9/4/02 with diagnoses of diabetes, and a right hip fracture. On 11/18/08 at 8:30 a.m., an LN was observed to	F 252	At breakfast time in the Sycamore dining room residents will have their meal items taken off the plastic trays when served. **Other Residents** Through interview, chart review and assessment, the facility will identify other residents that require and/or desire medications to be administered during meal times. Those residents identified will be assessed and Care Plans updated as appropriate. **Facility Systems** Licensed Nursing Staff will be re-educated regarding expectation related to medication administration and review requirements for administration during meals.. **Monitor** DNS or designee will monitor through random audits for compliance. Results of these audits will be presented to facility's Performance Improvement Committee for tracking & trending. Further recommendations will be identified based on these reviews. **Completed December 24, 2008**	

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F 252	Continued From page 2 pass medications to the resident during her breakfast meal. Resident #16's current Comprehensive Care Plan Report (Care Plan), dated 8/19/08, did not document that the resident was to receive medications during dining. On 11/18/08 at 8:35 a.m., the LN was asked if she routinely gave Resident #16's medications to her during her meals. The LN stated she gave the resident her medications at meals because, "She is very fussy taking her meds [medications], and she can hardly get them down her unless they are taken at mealtime." On 11/20/08 at 10:00 a.m., the DON was advised of the above observations. She confirmed that she would check to see if there were any resident's care planned to receive their medications during meals. There was no additional documentation provided by the facility. 3 a. During observation on 11/18/08 in the Sycamore Dining room, staff started serving the breakfast meal trays at 7:30 a.m. At 7:38 a.m., an LN delivered medication to Resident #3 at the table. Six trays had been delivered at that time. At 7:42 a.m., a meal tray was delivered to Resident #17. b. During observation on 11/18/08 in the Sycamore dining room, the noon meal trays had all been served by 12:20 p.m. At 12:21 p.m., an LN delivered a cup of dietary supplement to Resident #18. c. During observation on 11/19/08 in the Sycamore dining room, the noon meal trays had	F 252		

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F 252	Continued From page 3 all been served by 12:20 p.m. At 12:50 p.m., an LN delivered medications to Residents #19 and #23 while they were eating. d. During observation on 11/19/08 in the Sycamore dining room, the evening meal trays were served starting at 5:30 p.m. At 5:30 p.m., an LN delivered medications to Resident #21 after 4 trays had been delivered. At 5:55 p.m., medications were left on the table in front of Resident #22. e. During observation on 11/18/08 in the Sycamore Dining room, staff started serving the breakfast meal trays at 7:30 a.m. Food and beverages were not removed from the plastic trays during the breakfast meal. The Comprehensive Care Plans Reports for all the noted residents were reviewed and none contained approaches for medications to be delivered during meals. On 11/20/08 at 10:00 a.m., the DON was advised of the above observations. She confirmed that she would check to see if any residents were care planned to receive their medications during meals. The facility provided no additional comments or documentation regarding this issue.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was	F 253	**F253** **Resident Specific** The facility identified location to place Lap Buddies during meal times to maintain cleanliness of devices for Resident # 6 & 8.	

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F 253	Continued From page 4 determined the facility failed to ensure cleanliness of two residents' lap buddies, upholstered chairs in the Sycamore dining room, an upholstered recliner and vinyl stool in the common area adjacent to the back nursing station, an upholstered sofa and loveseat in the alcove/TV area of the Sycamore dining room, and the activities room carpet. This affected 2 of 11 (#s 6 & 8) sampled residents with lap buddies and had the potential to affect all residents in the facility. Findings include: 1. Resident #8 was admitted to the facility on 11/07/08 with the diagnosis of Alzheimer's dementia with behavioral dyscontrol. On 11/19/08 at 5:40 p.m., Resident # 8's lap buddy was observed to be removed from the wheelchair by the staff for the evening meal in the Willow dining room. The lap buddy was placed on the floor leaning against the dining room wall. The LN, who provided feeding assistance to the resident, placed the lap buddy back on the resident's wheelchair without first cleaning it. 2. On 11/17/08 at 1:30 p.m. during the general observations of the facility, the following were observed: a. The bottom cushion of the green upholstered recliner in the common area across from the Willow dining room had what appeared to be a dried white substance on the front right side. b. At 1:31 p.m., the vinyl covering of a rolling stool located in the common area across from the Willow dining room was noted to have multiple cracked and open areas exposing the cushion underneath. These could result in skin tears.	F 253	The pink upholstered chairs in the Sycamore Dining room have been cleaned and debris removed. Chairs identified as having tears and/or cracks in upholstery will be replaced. The recliner in the back common area has been cleaned and the rolling vinyl stool was removed from common area. The identified couch and loveseat have been cleaned. The carpet in the activity area will be replaced. Activities will be relocated to another area of the facility until this has been done. **Other Residents** Facility rounds will be completed to identify other furniture concerns such as those identified during the survey. Furniture will be cleaned and/or replaced based on the identified issues. Facility's Executive Director will submit a Purchase Order for replacements of furniture needing to be replaced. **Facility Systems** Nursing staff were Re-In-serviced related to proper removal and placement of Lap Buddies during mealtime. Facility's staff have also received education regarding cleaning/ wiping off furniture after meals to remove debris / spills. Housekeeping's cleaning schedule has been revised and Housekeeping staff educated regarding the cleaning of furniture.	

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F 253	Continued From page 5 c. On 11/18/08 at 12:00 p.m., the couch and loveseat in the alcove/TV area of the Sycamore dining room was noted to have multiple dark stained areas. d. On 11/20/08 at 1:30 p.m., the carpet in the activities room across from room 117 was noted to have multiple small dark stains and 8 larger dark stains ranging in size from 4"x4" to 11"x14". On 11/20/08 at 2:00 p.m., the DON was advised of these issues. 3. Resident #6 was admitted to the facility on 5/11/07 with diagnoses of dementia and upper neck fracture. Resident #6's most recent quarterly MDS assessment, dated 10/27/08, documented the resident had severely impaired cognition and was totally dependent on one staff member for for locomotion, eating, and toileting. On 11/19/08 at 5:45 p.m., a LN was observed providing feeding assistance to Resident #6. Resident #6's lap buddy was removed from his/her wheelchair and placed on end, on the floor, and leaned against the base of an artifical tree. After completion of the meal at 6:30 p.m., the LN, who provided feeding assistance to the resident, placed the lap buddy back onto the resident's wheelchair without first cleaning it. On 11/20/08 at 10:17 a.m., the DON stated, "The lap buddies for Resident #s 6 & 8 should have been cleaned before placing them back onto the residents after eating."	F 253	**Monitoring** ED is responsible to oversee compliance. This will be monitored though routine facility rounds and review of cleaning schedules by the ED or designee. The findings of these rounds will be presented to the facility's Performance Improvement Committee for analysis / trending and further recommendations **Completed December 24, 2008**	

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F 253	Continued From page 6 4. On 11/17/08 at 2:07 p.m., the chairs in the Sycamore dining room were observed. Three out of four of the pink upholstered chairs had what appeared to be dried food debris on the chair seats. Eleven out of 12 green upholstered chairs had tears and cracks on the seats of the chairs. -At 2:13 p.m., the Administrator stated, "The chairs are in need of repair and capitol funds are projected to be used to replace the chairs after the first of the new year." -At 2:15 p.m., the Dietary Manager was observed cleaning the 3 pink upholstered chairs that contained the dried food debris.	F 253		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure services provided met professional standards of quality for safe administration of medication for 2 random residents (#s 17 & 20.) Findings include: "Nursing Interventions & Clinical Skills, 3rd Edition" by Elkin, Perry, and Potter states regarding medication administration on p. 420, "Remain with the client until the medication is taken. Provide assistance as necessary. Do not leave medication at bedside without a prescriber's order to do so." 1. Random Resident #20 was admitted to the	F 281	**F 281** **Resident Specific** The Nurse who did not observe the resident ingest her medications is no longer employed that this facility. Resident #17 has been discharged from the facility Licensed Nurse for Resident # 20 received education regarding the expectation that administration of medications must be observed unless resident has been assessed to be capable of self-administration and her Care Plan reflects this as appropriate.	

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F 281	Continued From page 7 facility on 08/16/08 with the diagnosis of low back pain. The comprehensive care plan report was reviewed and no evidence was present that Resident #20 was determined to be able to self-administer medications. On 11/19/08 at 6:25 p.m., the LN standing at the medication cart located at the entrance to the Willow dining room was observed to hand a medication cup containing pills to Resident #20's family member. The family member was observed walking to and entering the resident's room. The room was not within view of the LN that dispensed the medication. An interview with the family member on 11/19/08 at 6:35 p.m. confirmed that the family member administered Tylenol to the resident. The LN documented on the Nurse's Medication Notes that the resident was given, "Tyl ES [Tylenol extra strength] duo [two] on 11/19/08 at 6:35 p.m." The DON was informed of the medication issue on 11/20/08 at 2:00 p.m. She confirmed the resident was not assessed for self administration of medications and that there were no physician orders for him/her to do so. 2. Resident #17 was admitted to the facility on 9/14/08 with diagnoses of pyelonephritis, status post cerebral vascular accident and diabetes mellitus. On 11/19/08 at 5:55 p.m., a LN was observed during medication pass in the Sycamore dining room. The LN placed a cup of pills in front of the	F 281	**Other Residents** The facility will identify residents who have a desire to self-administer medications based on interviews. Those individuals will be assessed in accordance to facility's Self-Administration of Medication Policy & Procedures. Care Plans will be updated as appropriate for individuals identified as appropriate. **Facility Systems** Director of Nursing Service (DNS) is responsible to oversee. Licensed Nursing Staff will be re-educated regarding professional standards for medication administration and the facility's Policy and Procedure for Self-Administration of Medication. **Monitor** The DNS or designee will perform random audits for compliance. The findings of these audits will be reported to the facility's Performance Improvement (PI) Committee for tracking and trending and further recommendations as needed. **Completed December 24, 2008**	

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F 281	Continued From page 8 resident and left the room. Two other residents were seated at the same table. The med (medication) cup sat in front of the resident for several minutes. The resident took the pills from the cup and lined them up on the table, then took them one at a time. The LN was not in the room or within line of sight during this time. Resident #17's 11/08 Physician's Orders and 10/1/08 Comprehensive Care Plan Report were reviewed. The Care Plan did not contain approaches for self-administration of medications and there was not a Physicians order for self-administration. The DON was informed of the medication issue on 11/20/08 at 2:00 p.m. She confirmed the resident was not assessed for self-administration of medications, and that there was not a Physician's order for her to do so.	F 281		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to provide toileting and showering services to maintain grooming and personal hygiene for residents who were unable to carry out activities of daily living. This affected 2 of 11 sampled residents (#3 and #7). Findings include:	F 312	**F 312** **Resident Specific** Residents #3's bath schedule & care plan have been reviewed to determine schedule is appropriate and care plan accurate. Monitoring is in place to monitor for compliance. #7's Care Plan has been also been reviewed and determined to be appropriate related to resident's toileting needs. ADL Flowsheet has been updated to reflect resident's toileting schedule. CNA staff has been educated regarding resident's care plan.	

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F 312	Continued From page 9 1. Resident #3 was admitted to the facility on 10/23/07 with diagnoses of status post left hip fracture repair, atrial fibrillation and Parkinson's disease. The MDS annual assessment, dated 09/29/08, stated the resident required extensive assistance for bathing and hygiene with the aid of one person. Review of the Flow Sheet Record indicated the resident was to receive "CT/ST [Century tub/standard tub] bath two times per week with assist." The Flow Sheet Record showed no baths were documented between 10/12/08-10/18/08. The Flow Sheet Record documented one bath per week during the following seven weeks in 2008: 8/3 thru 8/9 8/17 thru 8/23 8/24 thru 8/30 8/31 thru 9/6 9/7 thru 9/13 9/21 thru 9/27 11/2 thru 11/8 There was no documentation the resident refused bathing. The DON was interviewed on 11/19/08 at 1:00 p.m. and was made aware of the bathing records. On 11/20/08 at 11:00 a.m., the DON provided written information stating the facility standard for bathing residents "is at least 2 baths per week." 2. Resident #7 was admitted to the facility on 07/18/08 with the diagnoses of bilateral pneumonia, thrombocytopenia, and diabetes mellitus type 2.	F 312	**Other Residents** Residents care plans related to bath schedule and toileting plan will be reviewed and adjustments will be made if appropriate. ADL records will be updated to reflect individual's current plan for toileting plan. **Facility Systems** DNS is responsible to oversee that residents' bath schedules and toileting plans are implemented as appropriate. The Nursing Staff will be educated regarding following bathing schedule, properly documenting refusals as appropriate. Nursing staff will also be educated on following an individual resident's toileting plan **Monitor** The DNS or designee will monitor through observations and chart reviews related to toileting and bathing according to individual resident's schedule. The results of these reviews will be presented to facility's Performance Improvement Committee for tracking and trending and further recommendations . **Completed December 24, 2008**	

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F 312	Continued From page 10 The MDS quarterly assessment, dated 10/27/08, stated the resident was frequently incontinent of bowel and bladder. A 9/12/08 bladder status evaluation stated the resident would benefit from prompted voiding. The care plan goal for toileting included "will complete toileting tasks with 1-2 assist." The care plan approach was to "toilet upon arising with am & pm care, before meals and rest periods and prn." During morning care on 11/18/08 at 7:30 a.m., the CNA was observed to check the resident's incontinent briefs and found them to be dry. The incontinent briefs were left on the resident. The resident was not offered toileting at this time. The resident was then dressed and wheeled to breakfast. The DON was interviewed 11/19/08 at 1:00 p.m. and was made aware of the lack of toileting. No further information was provided by the facility.	F 312		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record reviews, it was determined the facility failed to ensure that 1 of 11 sampled residents	F 323	**F 323** **Resident Specific** As reflected in the 2567's Statement of Deficiencies, Resident # 4 had been assessed and the use of the merry walker had been discontinued prior to the start of the survey. Since discontinuing the Merry Walker, the resident had not no further falls. Care Plan has been reviewed to determine it meets resident's current needs.	

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F 323	Continued From page 11 (#4) received adequate supervision to prevent falls. In addition, electrical cords were observed protruding into the walkways and had the potential to pose a trip hazard. Findings include: 1. Resident # 4 was admitted to the facility on 3/25/08 with diagnoses of vascular dementia, hypothyroidism, congestive heart failure, and breast cancer. Resident #4's most recent MDS significant change assessment, dated 9/24/08, documented: -Problems with short and long term memory. -Moderately impaired cognitive skills for daily decision making. -Unable to balance while standing without physical help. -Limited range of motion in one leg. -Partial loss of movement in one leg. -Devices and Restraint section coded, "Chair prevents rising." Resident #4's Comprehensive Care Plan Report (Care Plan), dated 10/2/08, documented: -"Merrywalker when out of bed r/t [related to] poor balance and cognitive impairment d/t [due to] dementia," updated 4/8/08. -"Encourage ambulation in merrywalker," updated 4/11/08. -"Falling Star Program-Place star symbol by name plate at room door," updated 4/11/08. -"Keep strap of Merrywalker between resident's legs," updated 7/3/08. -"Redirect from front areas when ambulation in merrywalker," updated 8/14/08. -"Check resident every thirty minutes while in merrywalker, release every two hours for ten minutes-reposition," updated 8/24/08. -"Interventions for calling out, intrusive wandering,	F 323	The electrical cords identified in room 110-B and 120-B electrical cords were removed from the walkway at the time that this was identified, eliminating this risk. **Other Residents** The facility identified that there are no other residents using a Merry Walker Device at this time. Individuals will be assessed on an individual basis for the implementation of devices. In addition, reassessments will be done as needed to ensure the devices remain appropriate as needed. The areas that are accessible to residents have been evaluated to identify and remove other potential hazards including trip hazards. The facility's Maintenance Director completed this review and the findings provided to the facility's E.D. **Facility Systems** Executive Director is responsible to oversee Accident and Incident process. The facility's Interdisciplinary Team will review residents in the future that may be identified as candidates for use of a Merry Walker or other device. The use of these devices will be monitored and continued use re-evaluated as needed. The facility's nursing staff have been re-educated regarding facility's Policies and	

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F 323	Continued From page 12 hx [history] of crawling out of merrywalker: 1) Toilet, 2) Redirect, 3) 1-1, 4) Offer food, 5) Activity, 6) Change position," updated 9/5/08. -"Bolster to front of merrywalker," updated 10/2/08. The resident's fall risk was assessed three times with a score of 14 or higher considered as "High Risk." On 3/25/08-a score of 21, 6/23/08-a score of 17, and on 9/25/08-a score of 23 was documented. According to the facility's Post Event Investigation/Interviews Form, the resident had ten unattended falls between 4/27/08 and 10/30/08 related to her merrywalker usage. Review of the resident's record and incident reports revealed the following summaries of incidents and interventions to prevent incidents from recurring. -4/27/08 at 1:15 a.m.- The resident was found sitting on the floor in front of her merrywalker. This was a non-injury fall. The resident was placed on 15 minute checks for 72 hours. There was no change in resident's Care Plan at that time. -5/1/08 at 1:25 a.m.- The resident attempted to sit down in the merrywalker and tipped the walker over and fell. An LN witnessed the incident. This was a non-injury fall. A urinalysis was conducted on the resident. Her Remeron medication was discontinued, and the facility checked to see if the merrywalker seat could be secured to the restraint. There was no change in the resident's Care Plan at that time. -5/27/08 at 6:15 a.m.- The resident was found on	F 323	Procedures related to supervision and accident prevention. Routine rounds will be completed to monitor for electrical cords that might pose a trip hazard. Fall interventions to ensure they are being implemented and that they are appropriate for the residents' current status. **Monitor** The Executive Director or Designee will make environmental rounds routinely to identify potential safety hazards. If identified, a plan will be implemented to address. The DNS or designee will continue to monitor the use of Merry Walker or other devices. If issues are identified, the facility will identify a plan to address any issue. The facility's Performance Improvement Committee will receive updates regarding the status of these issues to determine if additional action is warranted. **Completed December 24, 2008**	

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the floor of her room under the merrywalker. A CNA stated the,"Merry walker was not tipped over, but resident sideways in m/w [merrywalker] on floor with head propped on rail with right left under m/w and left on rail of m/w. Staff had to unhook strap and tilt m/w to get res [resident] out." The Event Committee Follow up on this incident stated resident just sat wrong in merrywalker and went to the floor. This was a non-injury fall. The recommendations was to have a merrywalker assessment. There was no change in the resident's Care Plan at that time.

A Merry Walker Performance Evaluation was completed by Physical Therapy on 5/29/08 and documented Resident #4 started using the merrywalker on 4/4/08. Physical Therapy stated the device was appropriate and would aid in ambulation.

-7/2/08 at 4:55 p.m.- The resident was found seated on the floor inside her merrywalker. Prior to the fall, the resident was noted to move her leg over the strap in the merrywalker. This was a non-injury fall. The facility staff were in-serviced to ensure the strap of the merrywalker was placed between the residents legs when she was in the merrywalker. The resident's Care Plan was updated on 07/03/08 to keep strap in between resident legs when the merrywalker was used.

-8/2/08 (no time of day was given)- The resident was found seated on the floor of the front dining room outside of the merrywalker. This was a non-injury fall. The staff was instructed to redirect the resident when she was located in the front of the building. The resident's Care Plan was updated on 8/14/08 to redirect the resident from front areas in the facility when she was in her

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F 323	Continued From page 14 merrywalker. -9/22/08 at 8:20 p.m.- The resident was found sitting on the floor of the dining room in front of her merrywalker. The doors to the dining area had been closed. This was a non-injury fall. The staff was in-serviced to keep the doors open to the dining room except when cleaning the room. The resident's Care Plan was not updated at that time. -10/2/08 at 5:00 p.m.- The resident was found sitting on the floor in another resident's room. The merrywalker was found intact with the belt still in place and in an upright position. This was a non-injury fall. A bolster was placed on the resident's merrywalker according to the Care Plan updated 10/2/08. -10/14/08 at 11:20 a.m.- The resident was found sitting on the floor inside the merrywalker. This was a non- injury fall. The Event Committee follow-up on the fall stated the resident stepped over the merrywalker strap and sat on the floor. The staff was in-serviced to, "Monitor resident while in merrywalker to ensure she does not put her leg over the safety strap and that safety strap is between her legs and as tight as possible while resident in merrywalker to prevent her from falling onto the floor." The Care Plan was not updated at that time. -10/23/08 at 2:55 p.m.- The resident was found seated on the floor in front of her merrywalker. This was a non-injury fall. The recommendation was to permanently secure the strap from slipping and to request an assessment from Physical Therapy due to the resident's history of multiple falls and crawls out of the merrywalker. There	F 323		

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was no Care Plan update at that time. The resident was not assessed by Physical Therapy at that time.

-10/30/08 at 10:15 a.m.- The resident was found on the floor of another resident's room out of her merrywalker. Resident stated she had pain all over, was given pain medications, and placed into her bed. The recommendation documented Physical Therapy to trial a wheelchair next week for the resident. There was no Care Plan updated at that time.

The Physical Therapy Merry Walker Performance Evaluation was documented on 11/05/08. The Physical Therapist changed the resident from ambulating in her merrywalker to ambulating in her wheelchair due to history of falls and resident crawling out of merrywalker.

A Post-Event Investigation/Interview dated 07/20/08, documented a bruise was found on the resident's right forearm. The Event Committee follow-up documented a 1-centimeter bruise on the resident's right forearm, and a 1.5-centimeter bruise to resident's left forearm in the same area as the right. "Res. [Resident] notes dangling arms when leans over merrywalker at times. Most likely bumped arms bilat [bilaterally] on merrywalker will encourage long sleeve use to help protect arms as will tolerate." The Resident's Care Plan was not updated at that time.

A Post-Event Investigation/Interview, dated 8/17/08, documented that the resident hit her elbow on the merrywalker when trying to take her clothes off and sustained a nickel-sized skin tear to her right elbow. The resident did not have arm protectors on at the time of the incident. Facility

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F 323	Continued From page 16 staff was in-serviced to place stockinettes on arms or long sleeves as per the Care Plan. The Care Plan was not updated until 8/18/08 and documented, "Stockinette or long sleeves on arms to prevent bruising/skin tears as resident will allow/tolerate." An Post- Event Investigation/Interview, dated 9/7/08, documented the resident sustained a 6 centimeter skin tear and, "was not wearing stockinette or arm coverings at the time of the incident." The staff were in-serviced to use protective arm sleeves on the resident. On 11/20/08 at 9:30 a.m., the DON was interviewed and asked why the resident was not reevaluated by Physical Therapy for the safety of the merrywalker restraint until 11/5/08, despite frequent falls between April and October 2008. The DON stated, "It seemed appropriate for her mobility, and I never thought it was falls rather than behaviors. The facility was reluctant to put her in a wheelchair and she has had unpaid consults with physical therapy throughout her stay. The resident's cognitive impairment was the biggest concern, fearing a decrease of her abilities." She also stated that the resident had a one day trial in a wheelchair previous to the 11/05/08 Physical Therapy assessment, and she (the resident) was unable to move the wheelchair. After the 11/05/08 assessment, the resident was placed in the wheelchair and adjusted to it very well, self propelling down the halls using the handrails to assist her mobility. The DON confirmed that there was no documentation of increased supervision other than when resident was placed on 15 minute checks between 4/3-4/5/08, 4/17-4/20/08, 4/27-4/28/08, 7/2-7/5/08, and 10/2/08. The DON stated," The	F 323		

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F 323	Continued From page 17 purpose was to keep her in the common areas for staff awareness." The facility failed to increase supervision of the resident while she was ambulating in her merrywalker to prevent falls and injuries. The merrywalker restraint posed a hazard to the resident as she sustained several falls and injuries while attempting to exit the merrywalker unattended by staff. 2. On 11/17/08 at approximately 10:30 a.m. during the initial tour of the facility, electrical cords plugged into a power strip were observed protruding into the walkways of resident rooms 110-B and 120-B. These cords created a trip hazard for the resident, staff and public. On 11/20/08 at approximately 10:00 a.m., the electrical cord hazard was discussed with the administrator and maintenance person. The maintenance person acknowledged that the electrical cords presented a hazard.	F 323		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure staff providing perineal care and gastrostomy care washed their hands before proceeding with subsequent care for the residents. This affected 2 of 11 (#s 3 & 7) sampled residents. Findings	F 444	**F 444** **Corrective Measures** Nursing staff member identified at the time of the survey was re-educated on proper handwashing with glove use. This included a return demonstration for proper technique. This was the same individual for both residents # 3 & 7.	

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F 444	Continued From page 18 include: According to October 25, 2002, Center for Disease Control guidelines, "The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination and protect patients and health care personnel from infection." The facility's handwashing policy stated: "The hands are to be washed: between tasks and procedures on the same resident when contaminated with body fluids to prevent cross-contamination of different body sites; after removal of medical/surgical or utility gloves." 1. Resident #3 was admitted to the facility on 10/23/07 with diagnoses of status post left hip fracture repair, atrial fibrillation and Parkinson's disease. Resident #3's a.m. care was observed at 7:10 a.m. on 11/18/08. After completing perineal care and changing the attends with gloved hands, the CNA removed the gloves but did not decontaminate his/her hands before dressing the resident and handling the resident's shaver. The CNA then used hand sanitizer to decontaminate his/her hands. The DON was informed about the handwashing on 11/20/08 at 2:00 p.m. 2. Resident #7 was admitted to the facility on 07/18/08 with the diagnoses of bilateral pneumonia, thrombocytopenia and diabetes mellitus type 2.	F 444	**Other Residents & Facility Practice** Nursing staff will be re-In-Serviced on proper handwashing to include hand hygiene upon removal of gloves. This will address any other residents with potential to be impacted. Newly hired staff are required to demonstrate proper handwashing as part of their orientation. **Monitor** DNS is responsible to ensure nursing staff washes their hands in accordance to our P&P and Professional Standards. DNS or designee will complete observations of care delivery and observe for proper technique of hand hygiene, including handwashing upon removal of gloves before providing additional care. Findings will be reported to the facilities Performance Improvement (PI) committee for tracking and trending and further recommendations as needed. **Completed December 24, 2008**	

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	135010	A. BUILDING _____ B. WING _____	11/20/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEISER REHAB & CARE CTR	331 EAST PARK STREET WEISER, ID 83672

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F 444	Continued From page 19 Resident #7's a.m. care was observed at 7:30 a.m. on 11/18/08. After completing gastrostomy care with gloved hands, the CNA removed the gloves and did not decontaminate his/her hands before dressing the resident and placing the resident in the wheelchair. The DON was informed about the handwashing on 11/20/08 at 2:00 p.m.	F 444		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure the call light in Resident 6's room was functioning properly. This affected 1 of 11 sampled residents and had the potential to affect all residents residing in the facility. Findings include: Resident #6 was admitted to the facility on 5/11/07 with diagnoses of dementia and fracture odontoid (of the neck) type 2 and type 3. Resident #6's most recent quarterly MDS assessment, dated 10/27/08, documented the resident had severely impaired cognition and was totally dependent on one staff member for for locomotion, eating, and toileting. On 11/19/08 at 5:45 p.m., two surveyors attempted to activate the call light adjacent to the	F 463	**F 463** **Corrective Measures** Resident # 6'S call light cord was replaced by the Administrator and checked to verify it was working at the time that this was identified during the survey. **Other Residents** Other Call Lights were checked and found to be in operational order. **Facility Systems** Facility Staff have been re-inserviced on use of Maintenance Log to alert Maintenance Director if a call light cord is found not to be operating.	

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F 463	Continued From page 20 resident's bed. The call light did not activate an alarm outside of the resident's room. The surveyors did not observe or hear an alarm activate at the nurse's station for Resident #6's room. The Administrator was then informed of the resident's nonfunctioning call light. On 11/19/08 at 6:03 p.m., the Administrator verified the call light did not activate an alarm for the resident's room. At 6:05 p.m., the Administrator said, "The call light cord was replaced and the call light is now working." On 11/20/08 at 11:00 a.m., the maintenance supervisor stated, "I check call lights often." The surveyor asked when was the last time that Resident #6's call light was checked. The maintenance supervisor stated, "Probably the day before yesterday [11/18/08]." The maintenance supervisor then provided the surveyor with Resident #6's call light cord that was not working. The surveyor observed one attached wire and one broken wire where the cord attached to the button end of the call light.	F 463	**Monitor** Maintenance Director is responsible to monitor the call light system. The Administrator and Maintenance Director will do random checks of resident call cords. Findings will be reported to the facility's Performance Improvement (PI) committee for tracking and trending and further recommendations as needed. **Completed December 24, 2008**	

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey and Complaint Investigation of your facility. Surveyors conducting the survey were: Karen Marshall, MS, RD, LD, Team Coordinator Lea Stoltz, QMRP Lynda Evenson, BS, RN Amanda Bain, RN Survey Definitions: MDS = Minimum Data Set RAI = Resident Assessment Instrument RAPS = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record PRN = As needed FDA = Food and Drug Administration CNS = Central Nervous System RCM = Resident Care Manager	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Weiser Rehabilitation & Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED DEC 22 2008 FACILITY STANDARDS	
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility	C 361	**See F252 and F253**	

Bureau of Facility Standards

Gerald Bose — TITLE: Executive Director — (X6) DATE: 12-18-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

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C 361	Continued From page 1 in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F252 and F253 as it related to clean, comfortable enviornment.	C 361		
C 669	02.150,03 PATIENT/RESIDENT PROTECTION 03. Patient/Resident Protection. There is evidence of infection control, prevention and surveillance in the outcome of care for all patients/residents as demonstrated by: This Rule is not met as evidenced by: Please refer to F444 as it related to lack of hand washing when providing resident cares.	C 669	**See F444**	
C 745	02.200,01,c c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it related to professional standards.	C 745	**See F281**	
C 785	02.200,03,b,i i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Refer to F312 as it related to cleanliness of the	C 785	**See F312**	

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C 785	Continued From page 2 body.	C 785		
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F323 as it related to accidents.	C 790	**See F323**	